



**Schedule of Payments
(Maryland Select)
\$1,500 Deductible Open Access
with Integrated \$15/25/50 Rx**

The benefits outlined in this Schedule are in addition to the benefits offered under Coventry Health Care of Delaware, Inc. Small Employer Health Plan and Standard Package Cost Sharing for Maryland Small Employers. The benefits described herein are chosen at the Small Employer's option for an additional Premium to provide lower cost sharing for Members.

	Participating Provider MEMBER RESPONSIBILITY
Contract Year Deductible¹ Individual Family <i>(Except for covered Tier 1 Drugs, Primary Care Office Visits, Well-Child Visits, and Adult Preventive Care Services described below, there is a combined annual deductible for all Covered services, including prescription drugs.)</i>	\$1,500 \$3,000
Contract Year Out-of-Pocket Limit² <i>(Includes Deductible, Coinsurance, and Emergency Room Copayments)</i> Individual Family	\$4,900 \$9,800
COVERED SERVICES (Deductible applies, as indicated)	
Physician Services Child Well Care and Immunizations Adult Preventive Care Services – Not subject to the deductible. Eligible expenses include routine physical examinations, routine gynecological examinations, pap smears, routine mammograms, and prostate screening Primary Care Services Specialty Care Services	 \$0 Copayment per visit \$0 Copayment per visit \$25 Copayment per visit Deductible applies, then \$40 Copayment
Urgent and Emergency Care Services At an Urgent Care Center At a Hospital Emergency Room <i>(waived if admitted)</i> Ambulance <i>(Coventry Health Care of Delaware, Inc. must be notified within 48 hours of initial treatment in an emergency)</i>	 Deductible applies, then \$40 Copayment Deductible applies, then \$100 Copayment Deductible applies, then \$0 Copayment
Inpatient Hospital Care Semi-Private Room or Private Room when Medically Necessary • Medications & Drugs • Nursing Care • Intensive / Coronary Care • Radiation Therapy • Administration of Blood • Transplant Services • X-rays and Laboratory • Professional Services	Deductible applies, then \$250 Copayment per admission
Outpatient Surgery Free-Standing Surgi-Center Outpatient Department of a Hospital	Deductible applies, then \$0 Copayment Deductible applies, then \$0 Copayment

	Participating Provider MEMBER RESPONSIBILITY
Outpatient Laboratory / Outpatient Diagnostic Services X-ray and Ultrasound Laboratory Specialized Radiology (including CAT, MRI, MRA, PET)	Deductible applies, then \$0 Copayment Deductible applies, then \$0 Copayment Deductible applies, then \$0 Copayment
Short-Term Therapies Physical • Speech • Occupational • Respiratory • Cardiac Rehabilitation. <i>(Short-term Therapies are covered for up to 30 visits for each therapy per condition per Contract Year)</i>	Deductible applies, then \$40 Copayment
Habilitative Services For children up to and including the age of 19 years for services including occupational therapy, physical therapy, and speech therapy.	Deductible applies, then \$40 Copayment
Voluntary Family Planning Infertility Services (after confirmed diagnosis)	Deductible applies, then 50% Coinsurance
Skilled Nursing Facility Facility, supplies and equipment authorized in lieu of acute care hospitalization within the service area for up to 100 days per Contract Year.	Deductible applies, then \$40 Copayment per day
Home Health Care Authorized in lieu of acute care hospitalization within the service area.	Deductible applies, then \$0 Copayment
Hospice	Deductible applies, then \$0 Copayment
Prosthetic Devices and Durable Medical Equipment (DME) Authorized certain prosthetic devices and durable medical equipment	Deductible applies, then \$0 Copayment
Chiropractic Services <i>(Limit of 20 visits per condition per Contract Year)</i>	Deductible applies, then \$40 Copayment
Outpatient Mental Health and Substance Abuse Services (Medication Management Visits are not counted towards Outpatient Mental Health Visits)	Deductible applies, then 30% Coinsurance
Inpatient Mental Health and Substance Abuse Services Inpatient Hospital Care and Residential Crisis Services (up to 60 days per Contract Year) Physician Inpatient Services <i>(2 days of partial hospitalization may be substituted for 1 day of inpatient hospital care)</i>	Deductible applies, then \$250 Copayment per admission Deductible applies, then \$25 Copayment
Prescription Drugs All prescriptions are subject to the same deductible as all other medical services, except Tier 1 drugs (drugs that require prior authorization are identified in the Formulary with "PA" next to the name of the drug): Tier 1 or Tier One The group of medications on our Formulary that includes: 1. generic Prescription Drugs that we have designated as Tier One; 2. the select brand name Prescription Drugs that we have designated as Tier One; and 3. non-Prescription Drugs that we have designated as Tier One	Not subject to deductible. The lesser of a \$15 copayment per Prescription or refill, or the cost of the drug (Lesser of a \$30 copayment per prescription or refill for a 90 consecutive day supply for Maintenance Drugs, or the cost of the drug).

	Participating Provider MEMBER RESPONSIBILITY
Tier 2 or Tier Two The group of medications on our Formulary that includes: <ol style="list-style-type: none"> 1. brand name Prescription Drugs we have designated as Tier Two; 2. brand name contraceptives that we have designated as Tier Two; 3. brand name Prescription Drugs that have a narrow therapeutic index (those for which the dose must be monitored through laboratory tests) that we have designated as Tier Two; 4. brands that have newly introduced generics that we have designated as Tier Two; and 5. drugs designated as "DESI drugs" by the U.S. Food and Drug Administration ("FDA") that we have designated as Tier Two. ("DESI drugs" are being reviewed for their effectiveness by the FDA because they were approved solely on the basis of their safety prior to 1962.) 	Deductible applies, then the lesser of a \$25 copayment per Prescription or refill, or the cost of the drug (Lesser of a \$50 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs, or the cost of the drug).
Tier 3 or Tier Three Tier Three coverage includes Prescription Drugs that are not otherwise excluded under your Group Contract and that are not designated as Tier One or Tier Two, including brand name and generic Prescription Drugs that are not on our Formulary.	Deductible applies, then the lesser of a \$50 copayment per Prescription or refill, or the cost of the drug (Lesser of a \$100 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs, or the cost of the drug).
Self Administered injectable (other than insulin) <i>Not available by mail order</i>	Copay is 50% of the allowable charge not to exceed \$75, after the Deductible. The cost-sharing applies to both maintenance and non-maintenance drugs.

Participating Pharmacy Allowable charge means charges for Prescription Drugs dispensed at a Participating Pharmacy that are equal to: the contracted rate or the rate the Health Plan has agreed to pay.
Non-Participating Pharmacy For Prescription Drugs dispensed at a Non-Participating Pharmacy, the allowable charge is calculated as the reasonable cash value of each service.
¹ Deductible: The individual Deductible for individual coverage is a limit on the dollar amount of allowable charges You must pay per contract year before you receive benefits. The individuals within a family unit can access coverage from the plan once their individual deductible has been met.
² Out-of-Pocket Limit: Article 1.9 of the Group Membership Agreement (GMA) is amended to read as follows: The individual Out-of-Pocket Limit for individual coverage is the dollar amount a Member will have to pay out of his or her pocket per contract year. When a Member has reached the individual Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year, except for Covered Services requiring a copayment (excluding Emergency Room copayments). The family Out-of-Pocket Limit is the dollar amount members of the same family will have to pay out of pocket in aggregate per contract year. When a family has reached the family Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year for all family members, except for Covered Services requiring a copayment (excluding Emergency Room copayments). The Out-of-Pocket Limit includes the deductible, coinsurance, and Emergency Room copayments.
Benefits are administered on a Contract year basis. For Non-Participating Providers, Eligible Charges are based on the lesser of the provider's billed charges or our Out-of-Network Rate, which is defined in your GMA. In addition to your Copayment or Coinsurance, you are responsible for paying Non-Participating Providers the difference between our Out-of-Network Rate and their actual charge for non-emergency services. Your Out-of-Pocket costs for non-emergency care from Non-Participating Providers may be substantial.
This plan is underwritten by Coventry Health Care of Delaware, Inc. Refer to your GMA, applicable Riders, and this Schedule of Payments to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

PLEASE NOTE THAT THERE ARE LIMITED CIRCUMSTANCES WHEN YOU MAY RECEIVE COVERED SERVICES FROM AN OUT-OF-NETWORK PROVIDER, **FOR EXAMPLE, FOR EMERGENCY SERVICES**. IF YOU RECEIVE SERVICES FROM AN OUT-OF-NETWORK PROVIDER, YOUR COINSURANCE AMOUNT, IF APPLICABLE, WILL BE APPLIED TO THE OUT-OF-NETWORK RATE TO DETERMINE HOW MUCH WE PAY FOR COVERED SERVICES PROVIDED BY THE OUT-OF-NETWORK PROVIDER. *Based on your benefit plan, You may have limited coverage for out-of-network services. Please review your group membership agreement carefully regarding when out-of-network services may be included in your coverage.*

Out-of-Network Rate: The Out-of-Network Rate is the rate we pay for claims for services rendered by a non-Participating Provider. We will pay the claims as follows:

- claims submitted by a hospital will be paid at the rate approved by the Health Services Cost Review Commission;
- claims submitted by a trauma physician for trauma care rendered to a trauma patient in a trauma center will be paid at the greater of:
- 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or
- The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and
- Any other health care provider:
- For an evaluation and management service, no less than the greater of:
- 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with the health maintenance organization; or
- 140% of the rate paid by Medicare, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; and
- For a service that is not an evaluation and management service, no less than 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, to a similarly licensed provider under written contract with the health maintenance organization for the same covered service.

Calculation of rate – This provision applies to health care providers other than hospitals and trauma physicians. The Health Plan will calculate the average rate paid to similarly licensed providers under written contract with the health maintenance organization for the same covered service by summing the contracted rate for all occurrences of the Current Procedural Terminology Code for that service and then dividing by the total number of occurrences of the Current Procedural Terminology Code.

This is not a contract or a definitive statement of benefits. It is intended solely to provide you with an overview of the proposed Coventry benefits. Complete details of benefits, terms and exclusions are governed by your Coventry Group Membership Agreement (GMA). **The Coventry GMA may not cover all your health care expenses. Read your GMA carefully to determine which health care services are covered. If you have questions call us toll free at 1-800-833-7423.**